Community Response Program (CRP) Pilot Initiative

Final Implementation Report to the Wisconsin Children's Trust Fund

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Background

Differential response (also called "alternative response") reforms in child protective service (CPS) systems have proliferated in the U.S. over the past 15 years.[1] Such reforms entail changes to the way in which CPS systems assess and serve families reported for maltreatment according to the severity of their presenting risks. Higher risk families are assigned to more traditional "investigatory" tracks designed to ascertain evidence of abuse or neglect; when evidence is identified, these families are required to participate in CPS. Low to moderate risk families are assigned to an alternative track, in which workers assess family-identified service needs and encourage, but do not require, service participation. Although models vary, most of these "assessment" tracks are maintained within CPS systems. Regardless of which track a family is assigned to, however, those with lower levels of risk may still be screened out of CPS altogether at the maltreatment report or investigation stage.[2] In the State of Wisconsin, data show that 51% of the referrals of alleged maltreatment are screened out by CPS agencies.[3] Furthermore, the majority (85%) of assessments conducted on families who are screened in following a child maltreatment referral result in decisions that the children in the home are safe.[4] CPS is not required to offer services to families screened out of the system, and most often the CPS case is closed at this point.

Community Response Programs reach out to families who traditionally have been brought to the attention of CPS but are ultimately not served by that system. The program is intended to partner with CPS to reach out to families earlier when they are facing stress in an effort to reduce future referrals to CPS and ultimately to prevent child abuse and neglect. Community response differs from differential/alternative response programs in that the population of interest is families that have been referred to CPS but screened out or closed after an investigation with no identified safety risks.

As indicated in Figure 1, community response lies on a continuum of child maltreatment prevention and intervention services. Families screened out following a maltreatment report or investigation still may have need for services, and if so, can be considered potential targets for early intervention. Efforts to systematically engage this population are scarce, despite research evidence that such families have a significant risk of being re-reported to CPS over time.[5] To the

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[1] See, e.g., the U.S. Department of Health and Human Services literature review (2009), "Differential Response in Child Protective Services: a Literature Review"; the American Humane Association's *Protecting Children* (2005), special issue (volume 20, Numbers 2 and 3) devoted to "Differential Response in Child Welfare"; Waldfogel, Jane. (2008) "The Future of Child Protection Revisited," pp. 235-241 in Duncan Lindsey and Aron Shlonsky (Eds.). *Child Welfare Research: Advances for Practice and Policy.* Oxford: Oxford University Press.

[2] In Wisconsin, when maltreatment reports are screened-in, an "initial assessment" is conducted to determine what safety factors and protective capacities are in place, and to make further decisions about whether and how to serve families reported for maltreatment. In many other states, this phase of CPS intervention is referred to as the "investigation."

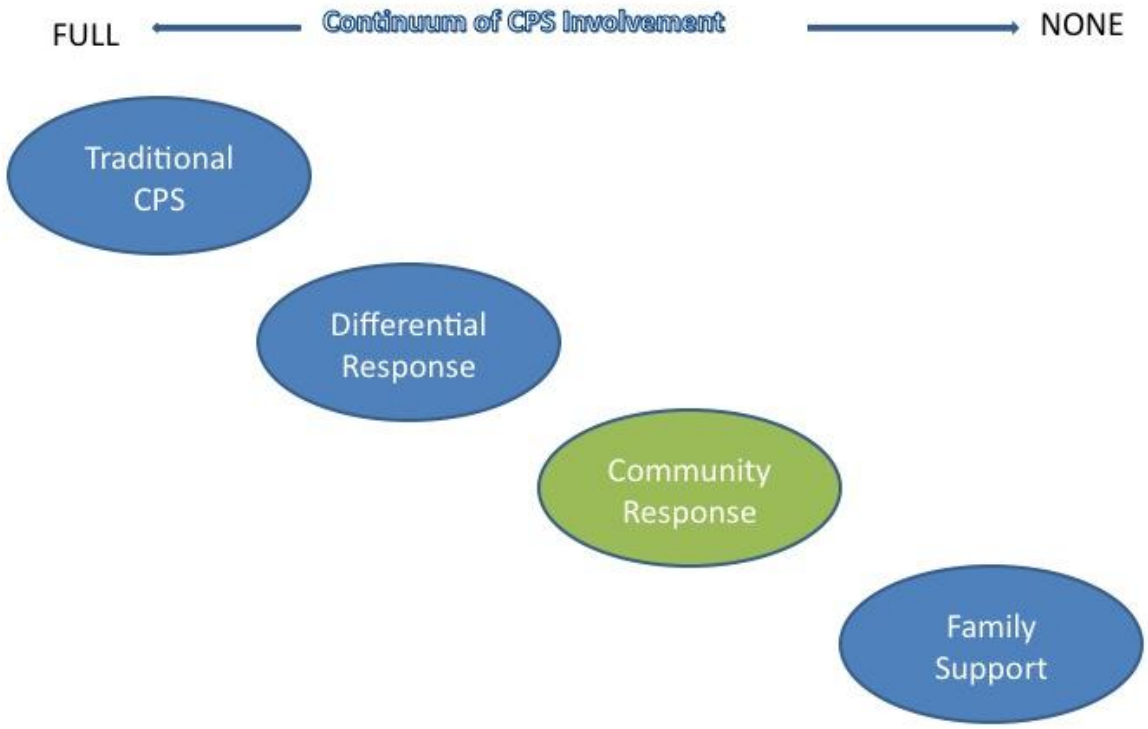
[3] Office of Program Evaluation and Planning, Division of Children and Family Services, Wisconsin Department of Health and Family Services. (2006). *Wisconsin Child Abuse and Neglect Report: 2006 Data*. Madison, WI:

[4] Wisconsin Department of Children and Families, http://dcf.wisconsin.gov/children/CPS/PDF/2007CAN Report.pdf

[5] See Drake, B., Jonson-Reid, M., Way, I., & Chung, S. (2003). Substantiation and recidivism. *Child Maltreatment, 8*(4), 248; Hindley, N., Ramchandani, P., & Jones, D. (2006). Risk factors for recurrence of maltreatment: a systematic review. *Archives of Disease in Childhood, 91*(9), 744-752.

extent that services to families who are reported to but not served by can prevent future maltreatment, it may be socially and economically responsible to target and engage this population of families in services designed to ameliorate risks and promote family strengths associated with child safety and well-being.

Figure 1 Continuum of child maltreatment prevention and intervention services



In 2006, the Wisconsin Children's Trust Fund provided pilot funding to six sites across the State to develop Community Response Programs (CRPs) that address the needs of families that are screened out of CPS following a report or investigation. In 2008, CTF funded four additional sites and added one more in 2009. The stated goals of the CRPs are:

1. To provide comprehensive voluntary service to families that are reported to, but not served by, the CPS system;

2. To reduce demands on the CPS system, which has sometimes relied on limited resources to serve families who are screened out;

3. To prevent re-reports to CPS related to the escalation of risks; and

4. To build a more comprehensive, community-based service continuum for families at risk for maltreatment.

While the eleven funded sites all shared similar target populations (i.e., families who were reported to but not served by CPS and voluntarily engaged in CRP), the programs were locally adapted to meet the needs of individual community contexts. The sites varied in their CRP service models in terms of the duration of service, the nature of the service intervention, and whether the CRP service track was delivered by CPS workers or by a community-based private agency. In terms of the target population, sites varied on whether they served families who were screened out of CPS at the Access[6] or report stage, families who had an initial assessment (i.e., investigation) from CPS but subsequently had their case closed, or families who had received a services intake[7] report from CPS. The variation in the duration of service and nature of service intervention were related. Specifically, sites that were located in relatively resource rich areas are able to provide more referrals to other services, thus allowing for a shorter time period of intervention, while sites that were located in more remote areas tended to provide more intensive services.

The Children's Trust Fund contracted with the Institute for Research on Poverty (IRP) at the University of Wisconsin-Madison to conduct an implementation evaluation of the original CRPs funded in 2006, and beginning in 2008, the additional five sites funded by the Trust Fund. Consistent data collection protocols were used across sites to document characteristics of the families referred to the program, the referral concerns, outreach efforts, service plan and progress, case closure, and follow-up (see Appendix A for program forms). The implementation evaluation involved the following tasks:

1) An assessment of the extent to which CRPs were implemented according to the original service models proposed by sites;
2) Identification of the factors that predicted family engagement with and attrition from CRP;
3) Identification of the characteristics of families that participated in CRP, and the nature of their service needs;
4) Identification of the factors that predicted progress toward and attainment of service goals; and
5) An assessment of whether the CRP services were positively experienced by families, and whether families had suggestions for improving the program models.

An interim implementation report was developed for CTF and delivered on November 18, 2008, and a final report was delivered on April 11, 2010. This report reflects the content in both the interim and the final reports to CTF. Because this phase of the evaluation was not designed to assess program impact, information on the relative efficacy of different CRP models is not

[6] In Wisconsin, "Access" refers to the part of the CPS system focused on taking and processing child maltreatment reports.

[7] Services intake is a category of CPS reports that is distinct from protective services reports, and more likely to involve needs related to community resource linkages or material resources. Services intake reports may result in an open "child welfare" case involving voluntary service delivery, but no other traditional CPS service interventions.

known. However, this evaluation generated important findings that inform best practices in designing and implementing CRP models.

Recommendations

- Community Response Programs should exclusively target families who were screened out or had their cases closed after an initial assessment by the CPS following a report of child maltreatment;
- Services should be truly voluntary in nature and delivered by staff operating outside of the formal CPS system; families should be free to decline services as well as disengage from services at any point;
- A pre-established protocol between the CRP service agency and the local CPS agency needs to be in place, including objective guidelines for referring families from CPS to CRP, ideally with very few criteria (e.g. every family who is screened out and has reasonable contact information);
- Goal setting should be a collaborative process between the CRP worker and the primary caregiver(s) in each family.
- The program should be delivered in the family's home or in a convenient location, as determined by the family;
- Comprehensive assessment of each family's economic situation should occur prior to goal setting, to allow families to reflect on whether they need assistance accessing economic resources, making short-term financial decisions, or addressing emergent economic needs.
- The intervention period should be relatively short (e.g., 1-6 months), and not serve as a substitute for other community resources that offer long-term interventions; clear criteria for case closure should be developed.

The CRP Models

The six original CRP pilot sites funded by the Children's Trust Fund include Columbia County (Family Resource Center, Renewal Unlimited), Green Lake/Marquette (combined county site; CPS), La Crosse County (Family Resource Center of La Crosse), Pierce County (CPS), Rock County (Exchange Family Resource Center), and Washburn County (Lakeland Family Resource Center). The Children's Trust Fund added four additional sites in 2008: Ashland/Bayfield (combined county site; Ashland/Bayfield Family Resource Center), Dane County (Joining Forces for Families), Manitowoc County (Lakeshore Family Resource Center), and Marathon County (CPS); and added Racine County (United Way of Racine County/Children's Service Society) in 2009. As noted, three of the eleven sites are internal to the local CPS office, and involve dedicated staff for the CRP. The remaining eight CRPs are housed in private, not-for-profit organizations. One of the sites (La Crosse) is co-located with the county CPS agency. Thus, the models varied according to whether they were internal or external to CPS and whether they were co-located with CPS agencies.

Regular meetings and conference calls with the pilot sites shed light on a number of implementation issues related to these model differences. Workers in sites with CRP models internal to the local CPS agency sometimes struggled with maintaining role separation from other CPS staff. CPS staff sometimes presumed or expected that certain CPS functions would be performed by the CRP worker. CRP models located in the community had very different implementation issues. For several of these sites, lack of formal lines of communication with CPS staff hindered the referral process to the CRP agency in the early stages of the initiative. CPS staff persons were sometimes reluctant to refer families to CRP because they were not familiar with the CRP model, or because formal protocols for referral were not in place or were viewed as cumbersome. Time for building relationships between CPS and CRP staff and developing a shared understanding of the CRP largely resolved such issues.

One key evaluation question in the implementation period was whether sites adhered to the model of service proposed in their initial grant applications. Most sites included general descriptions of "service flow" in the initial grant proposal to the Children's Trust Fund. However, these descriptions often lacked specificity at the proposal stage. Lack of detail on the intended service flow made it difficult to assess the extent to which sites maintained model fidelity. This lack of clarity was partially unavoidable at the onset, given the shortage of literature on similar models at the time the Children's Trust Fund announced the pilot funding.[8] Furthermore, the Children's Trust Fund's Request for Proposals articulated a commitment to allowing model variation as a means of generating information on a variety of community-based prevention approaches. Thus, little prescriptive guidance was provided to sites at the onset of this pilot initiative.

Given the initial lack of detail on program models, significant efforts by the Children's Trust Fund and the evaluators were put forth in the initial implementation phase in order to help sites more clearly articulate their service models. This process involved surveying sites on specific questions related to their intended target population, their referral and intake procedures, and the nature of their service intervention (See Appendix B). The results from this exercise helped clarify the differences among the CRP pilot models.

Although all sites focused on families who were reported to by not served by CPS following a report of child maltreatment, the sites varied according to whether they primarily or exclusively focused on families screened out at CPS Access (i.e., the report stage) or families that had their cases closed after Initial Assessment (i.e., the "investigation" stage). In the initial phase of implementation five sites offered services only to families who were screened out at Access. Screen-outs occurred because the report lacked sufficient evidence to further assess the claim, the report was not related to safety concerns, or the report was believed to be otherwise unfounded. One site offered services only to those families who had their cases closed after an initial assessment. Case closure after Initial Assessment occurred when there were no present safety concerns or immediate risks to the children in the home.

[8] A more recent volume of the American Humane Association's *Protecting Children (2008)*—special issue (volume 23, Numbers 1 and 2) devoted to "Exploring Differential Response: One Pathway toward Reforming Child Welfare"—includes articles on California's and Minnesota's differential response models, which both include a path of service that is community-based and external to CPS.

An unexpected finding in the latter stages of implementation was that all of the original CRP sites began receiving referrals for families whose reports to CPS resulted in a "services intake" rather than a "protective services" report.[9] The originally proposed CRP models did not include reference to services intake reports as a potential source of referrals. This change highlights the importance of revisiting the service model periodically to identify changes in practice. All CRP sites accepted referrals only if child safety concerns were absent; CRP staff persons referred families back to CPS if safety concerns were (or became) evident. However, across sites, CRP staff members felt the need to refer only 4% of families back to CPS.

The nature of services across CRP sites varied from linkages and referrals to multiple visits to the family's home (note: this is not the same as an evidence-based home visiting model) and family team meetings. After the initial referral to the CRP and outreach attempts by CRP workers, families were free to accept or decline services without consequence. CRP staff also referred the family to other existing programs or services at any point of contact, when these alternatives were deemed more appropriate. CRPs were not intended to duplicate services already available; rather they were intended to serve as a resource broker whenever possible. Families who engaged in CRP received tailored services that could include community resource referrals, family team meetings, emergency funds, parent education, mental health consultation, assistance with public benefits linkages, and transportation assistance, depending on the site model.

The duration of service also varied across sites. In one site, services were time-limited and cases closed after three months, regardless of whether the family achieved their goals prior to that time. In all other sites, services were not time-limited, and therefore ended only when the family achieved their goals, disengaged in the program, or when there were safety concerns that required a referral back to CPS. Duration of service did not necessarily relate to the intensity of the service array. For a small number of sites, however, open-ended service delivery became problematic, because it resulted in relatively few numbers of families being served during the implementation phase. For this reason, CTF recommends limiting service delivery time frames according to set criteria and clear case closure guidelines.

Discussions in multi-site meetings generated agreement that one key outcome of the CRP models was to prevent the recurrence of CPS referrals. Indeed, the main argument for serving lower-risk families is to prevent the escalation of risks and promote family strengths in order to avoid future incidents of child maltreatment. Although the present evaluation was not intended as an outcome evaluation (i.e., designed to assess program impact on participants), the Children's Trust Fund did expect information on how sites would be able to demonstrate "success."

Through a collaborative process involving CTF, the evaluators, and the original CRP sites, it was decided that an assessment of program success would be accomplished in three ways: the adherence to the intended model of service delivery; positive changes in a pre-post measure of family strengths completed by the primary caregiver in each family served; and positive feedback from participating families at the point of case closure. Another set of intermediate

[9] Services intake reports are typically considered low-risk, and do not meet the statutory criteria for abuse or neglect. However, these cases typically involve some degree of service need, often at the request of the family.

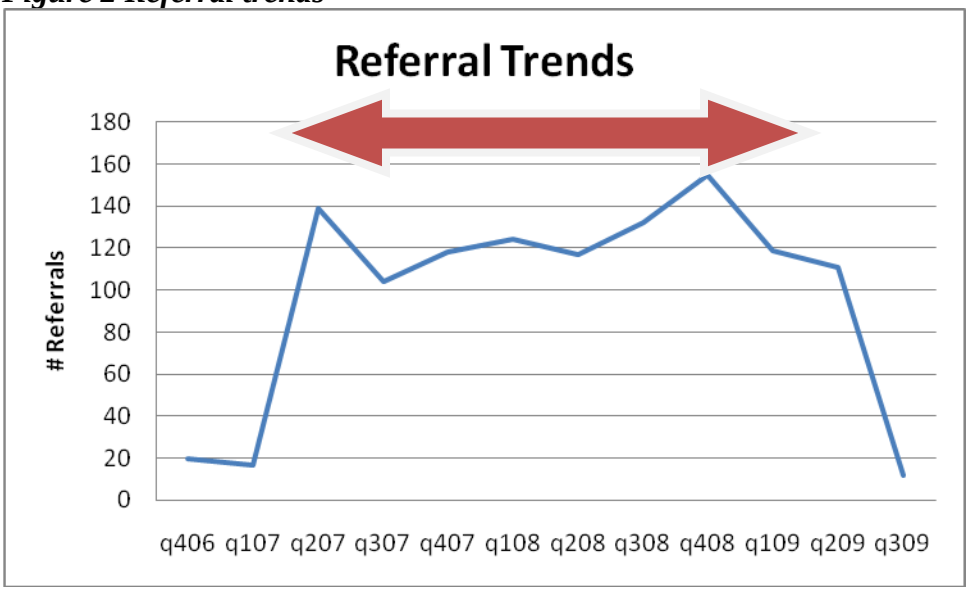
outcomes related to the successful implementation of the program (e.g., rate of engagement, rate of program form completion, attainment of service goals) was also tracked. Additional measures of success monitored by the Children's Trust Fund included feedback from the sites on how their practice with families changed in positive ways, the extent to which new community partnerships were generated by the CRP, and feedback from families and workers on their views of the CRP captured in anecdotal success stories.

In summary, sites' CRP models varied across several dimensions, including their physical and organizational relationship to the county CPS agency, their outreach and engagement strategies, and their mix and duration of services. No one model emerged as the "ideal" structure for CRP, but several findings from the implementation evaluation lend weight to the recommendations outlined above. Furthermore, important findings (presented below) related to the characteristics of the families referred to CRP sites, their service needs, and the predictors of engagement and goal attainment will assist other localities in planning and launching CRP models that target families with lower-level risks for child maltreatment—families not previously served by CPS systems.

Case Intake Patterns

Although the CRP initiative began in late 2006, the initially funded sites were not fully operational until mid-2007. Figure 2 depicts the trend in the number of referrals to CRPs between the fourth quarter of 2006 through the third quarter of 2009. As shown, the number of referrals climbed significantly during the first two quarters of the implementation period, as sites established or redesigned communication lines with child protective services staff. Referrals drop precipitously in the third quarter of 2009, but this is largely an artifact of how data are collected for the evaluation. Sites batch mail program service forms to the evaluation team for cases that close during each quarter. This process results in an under-representation of longer-duration cases in any given quarter, which is corrected over time as longer-term cases close. However, at the point that the evaluation period ended, some longer-term cases were still open.

Figure 2 Referral trends



The final report analyses involved data on cases that were opened between **July 1, 2007 and June 30, 2009** and for which program forms were received before October 15, 2009 (to afford an adequate time lag for capturing longer duration cases).

Overall, there were 869 initial referrals made to ten CRP sites[10] from July 1, 2007 through June 30, 2009. An additional 125 re-referrals (i.e., CRP referrals for families subsequent to an initial CRP referral) also occurred during this time period, the majority of which were from CPS (76%), followed by self-referrals (21%), and other agencies or community members (3%). Of the families that were re-referred through CPS, 4% of them had been re-referred to CPS by the CRP worker and 57% of them had previously engaged in CRP services.

54% of initial referrals resulted in a family's acceptance of CRP services; this acceptance rate ranged from 28% to 83% across sites. The most common reason that referred families did not accept services was that CRP staff persons were unable to contact them (23%). Additionally, 15% of families declined services, 4% were referred by CRP staff to other agencies at the time of the initial contact, and 4% were referred back to CPS by the CRP worker.

Sites varied according to the segment of the CPS population targeted for CRP services. Data from the 2007 Wisconsin Child Abuse and Neglect Report[11] show CPS referral pools that are significantly larger than the number of actual referrals to CRPs. Numbers of families referred to CRP from CPS over the period of a year ranged from 14 to 216 across sites, with an average of 64 families being served per site. From the available pool of potential referrals (i.e. the number of families that were in their target population from CPS), the referral rates ranged from 3% of potential families to 28%, with an average of 12% of potential families actually being referred to CRP from CPS.

Although several sites did not articulate specific criteria for prioritizing or selectively accepting referrals, anecdotal comments from CRP staff suggested that in most sites, CPS staff first screened cases for "appropriate" CRP candidates, and referred only this subset to the CRPs. Sometimes this screening process occurred in collaboration with CRP staff. As a result of the interim evaluation report from the fall of 2008, CTF clarified the referral process to encourage sites to ask CPS staff to use objective criteria for referrals. In replicating these CRP models elsewhere, application of objective criteria for CPS referrals is essential for learning whether particular characteristics of referred families are related to successful program outcomes.[12]

[10] Dane County is one of the five sites added to the CTF initiative in 2008. However, at the time that this report was written, no program service data had been submitted by this site.

[11] Wisconsin Department of Children and Families, http://dcf.wisconsin.gov/children/CPS/PDF/2007CAN Report.pdf

[12] Some sites may have been operating at capacity, and thus unable to handle a higher number of referrals. Regardless of capacity issues, however, clear and objective criteria should be in place to determine which referrals are ultimately made.

In Table 1, the characteristics of all initial referrals from CPS (N=821) are presented.[13] Sites were required to document available family demographic information on each referral, as well as characteristics related to the referrals (e.g., reason for referral to CRP, as determined by the CPS worker). Not all referrals from CPS contained information on family demographics; thus, certain estimates in Table 1 may not accurately reflect the percentage or average value for a particular characteristic. Characteristics for which there were significant missing data (i.e., > 10% but < 30% of the sample) are identified with a table footnote. Some characteristics, such as employment and education status, were omitted from the table because data were missing for 30% or more of the sample.

The vast majority of CRP families referred by CPS identified the primary caregiver as a white female whose primary language was English. Primary caregivers had an average age of 31 and an average of 2.1 children in the home. A small percentage of caregivers were pregnant at the point of the referral (6%), only 2% identified themselves as Hispanic or Latina, and 10% identified their race as black. Approximately 16% reported a personal disability, and 16% reported having a child with a disability. Half of referred caregivers were married or cohabiting with a partner. The only statistically significant difference in family characteristics across referral outcome status was primary language; nearly all (99%) families who accepted CRP services reported English as the primary language in the home. Those referred out to other services in the community or back to CPS were less likely to identify English as their primary language.

With respect to the case referral characteristics, the majority (62%) of initial referrals from CPS were from the screened-out pool. Referral outcomes varied greatly by the referral pool. Of the families that were screened out, 29% were unable to be located, 18% declined services, and 43% accepted services. In contrast, of the families that were from the services intake pool (22% of all referrals from CPS), 9% were unable to be located, 6% declined services, and 74% accepted services. Finally, of the families who received an initial assessment from CPS[14] (9% of all referrals from CPS), 25% were unable to be located, 19% declined services, and 56% accepted services. This suggests that sites most commonly received referrals from the screened out pool, but were less successful at engaging these families compared to families referred from the services intake or initial assessment pool.

When CPS made a referral to a CRP site, CRP staff collected information on the reasons for the referral to CRP, as identified by the CPS worker.[15] The most common reasons reflected parenting or home environment problems (76%), followed by reasons related to the well-being of the primary caregiver (i.e., health or mental health needs, alcohol or drug abuse issues, domestic violence; 39%), assistance with linking to other community resources (28%), income or

[13] Approximately 6% of all initial referrals from Table 1 are excluded because the referral source was not CPS. As prescribed by the Children's Trust Fund, CRP sites were expected to limit their referral pool to families referred by CPS. However, in the earliest stages of implementation, this criterion had not yet been established, and a small number of initial referrals came from other sources (e.g., Early Head Start, schools, self-reports).

[14] Nearly all families referred from the initial assessment pool involve cases that are assessed and then closed at this stage; however, a few families are referred from an open initial assessment case.

[15] This referral reason is not necessarily associated with the allegations that initiated the maltreatment report. Rather, these reasons are based on the CPS worker's assessment of what the family may need or benefit from.

benefits-related needs (i.e., benefits linkage, employment needs, housing problems, food shortages, utility shut-offs; 26%), and behavioral and emotional health needs related to one or more children in the home (11%).[16] Multiple referral reasons were often provided for a family. Across referral outcome categories, statistically significant differences in referral reasons emerged for the income-benefits and other community resources categories. Families referred for income-benefits related needs were more likely to accept CRP services than they were to decline services or be referred elsewhere. Families needing linkages to other community resources were more likely to be referred elsewhere (including back to CPS) than they were to accept or decline services.

[16] Several other referral reasons reflected in the CRP service intake form have a very low incidence; these reasons are not included in Table 3.

Table 1 Characteristics of referrals

	All Initial Referrals (N=821)	Accepted (N=430)	Declined (N=125)	Unable to Locate (N=196)	Referred Out (N=35)	Referred back to CPS (N=35)
Characteristics	**% or mean**	**% or mean**	**% or mean**	**% or mean**	**% or mean**	**% or mean**
Family characteristics						
PC[1] female	92%	91%	92%	91%	94%	94%
PC age[2]	31.1	31.6	30.0	30.3	35.6	30.3
Pregnant[2]	6%	6%	4%	7%	0%	9%
Race: white	82%	85%	82%	78%	71%	85%
Race: black	10%	11%	8%	9%	6%	6%
Race: other	8%	4%	10%	13%	23%	9%
Ethnicity: Hispanic	2%	3%	1%	1%	3%	6%
Primary language: English*	97%	99%	96%	96%	91%	94%
Cohabiting or married	47%	49%	49%	48%	37%	29%
Average number of children[2]	2.1	2.1	2.0	2.0	1.9	2.3
Disability of PC[2]	16%	19%	14%	11%	17%	11%
Disability of child[2]	16%	17%	10%	17%	20%	20%
Referral Characteristics						
CPS referral pool						
Screened out of CPS*	65%	54%	78%	81%	80%	63%
Services intake case*	23%	32%	10%	9%	20%	34%
Initial assessment	9%	10%	11%	10%	0	0
Unknown	3%	4%	2%	1%	0	3%
Referral reasons[3]						
Income/benefits-related*	26%	29%	22%	26%	6%	17%
Parenting/home environ.	76%	74%	78%	80%	69%	77%
Parental well-being	39%	37%	46%	42%	29%	31%
Child behavior	11%	10%	13%	12%	14%	9%
Other resource needs*	28%	29%	29%	21%	37%	44%
Prior CPS involvement[2]						
yes	57%	57%	62%	56%	46%	54%
no	33%	35%	26%	30%	37%	34%

*Denotes statistically significant differences across groups at the .05 level, determined with Chi-square or one-way ANOVA 2-tailed tests.

[1]PC=Primary caregiver.

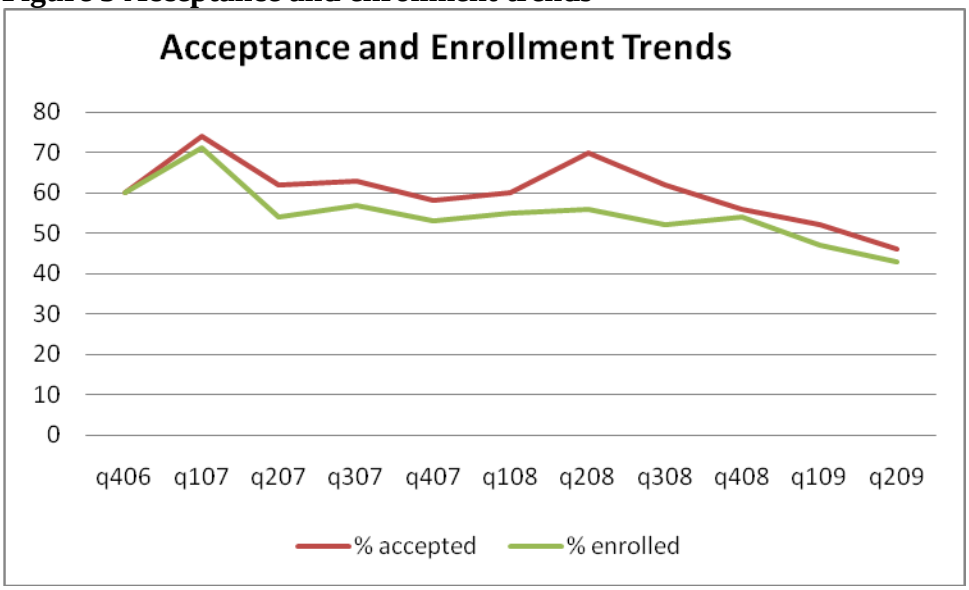
[2]Denotes measures with significant (>10%) missing data.

[3]Families may have multiple referral reasons, so cells do not sum to 100%.

Although a benchmark for engagement was not prescribed by the Children's Trust Fund, it was presumed that at least initially, CRP acceptance rates (i.e., rates of family agreement to participate in CRP services) would be low, given the lack of community familiarity with this type of service model. Although a downward trend may be anticipated during the early quarters of implementation as service capacity is reached, only six of the 821 initial referrals from CPS during the implementation period were unable to be served by CRPs due to program capacity limits, according to program service records. The slight downward trend depicted in Figure 2 during the earlier quarters is followed by relative stability in acceptance rates for the evaluation period that began in July 2007. The more pronounced downward trend in the later quarters of the implementation period may be explained, in part, by the fact that longer duration cases

remained open in more recent quarters. Since such cases, by definition, involve families that have accepted CRP services, their absence may artificially depress the acceptance rates. Rates of program enrollment (i.e., families that actually participated in CRP services after initial acceptance) are slightly lower than acceptance rates, but trend in parallel to family acceptance rates.

Figure 3 Acceptance and enrollment trends



Multivariate analyses (logistic regressions) were conducted predicting the odds of case acceptance, controlling for site, to determine the family demographic and referral characteristics that were most associated with this outcome. Referrals from the services intake pool were more than twice as likely as referrals from the screened out pool to result in CRP acceptance, adjusting for site. Referrals for income and benefits-related reasons were also twice as likely to result in CRP acceptance, compared to families referred for other community resource needs (although this finding is only marginally statistically significant, $p<.10$). With respect to family characteristics, black caregivers were more likely to accept CRP services than white caregivers, and caregivers with a personal disability were more likely to accept CRP services than those without a disability (marginally statistically significant, $p<.10$).

Enrollment and Progress in CRP

During the evaluation period for the implementation, there were 486 accepted referrals to CRPs. This number includes all referrals (regardless of initial versus re-referral status) from CPS for which the family agreed to participate in CRP services. Table 2 presents the distribution of the referral source for this group; the majority (54%) were from the screened out pool, 32% were from the services intake pool, 10% were from the initial assessment pool, and 4% had missing CPS referral pool information.

Table 2 CPS access – all accepted referrals from CPS (N=486)

Access Point	Number	%
Screened out	263	54%
Service intake reports	158	32%
Initial assessment completed	47	10%
Unknown/Missing	18	4%

Of the 486 accepted referrals, 435 (90%) had at least partially completed service forms upon case closure. Completion of an Enrollment and Progress form was considered evidence that a family actually enrolled or engaged in CRP services, since sites were required to complete this form on all program participants. This means that approximately 90% of the families that initially agreed to participate in CRP (i.e., those that accepted services) ultimately do so. Difference-of-means tests comparing the group of families that enrolled to those that accepted but did not enroll in services were conducted to assess whether referral or family demographic factors were correlated with enrollment. None of the family demographic factors distinguished enrollers from non-enrollers. However, among those accepting CRP services, families referred for an income or benefits-related reason were less likely to ultimately enroll in CRP than families referred for other reasons (28% vs. 41%). This finding may be explained, in part, by the ability of CRP staff to assist some families referred for income and benefit needs with very minimal contact (e.g., a phone call or series of phone calls), thereby reducing the likelihood of actual program enrollment following a family's agreement to participate in the CRP.

Although "screened-out" families were the most prevalent group of CRP participants, families referred from the screened-out stage were less likely to enroll than families referred from other CPS stages. Also, families referred from the services intake pool were more likely to enroll than families referred from other CPS pools. This analysis does not explain why families are more or less likely to enroll in CRP given these referral characteristics; however, it does suggest outreach efforts from the CRP sites may need to be tailored differently for families depending on the nature or level of CPS involvement at the point of the CRP referral.

There were several components to tracking the families that enroll in CRP. All families that were enrolled worked together with a CRP staff member to determine service goals and plans for meeting these goals (see Appendix A, Enrollment and Progress Form). Workers documented all the contacts that were made with the family (e.g., dates, mode, outcome) on a Contact Form, which also documented dates and reasons for case closure and referrals back to CPS. Additionally, enrolled families were assessed on their self-identified strengths (see Appendix A, Self Assessment of Strengths), and were offered a more comprehensive assessment of their potential eligibility for an array of public and private benefits (See Appendix A, Income and Benefits Form). A Feedback Form (see Appendix A) was also provided to the primary caregiver at case closure (or sent to families when case closure cannot occur in person) and families were asked to place the form in a stamped envelope addressed to the evaluators. These forms were then mailed from the sites or by individual caregivers to the evaluators. Workers also document whether emergency assistance "flex funds" were dispensed to the family (e.g., date, amount, reason), but this form was used only when flex funds were accessed.

Among the forms to be completed by CRP staff, the income and benefits form had the lowest completion rate (73%). In order to be counted as "complete," participants had to provide at least some information on income and benefits receipt. Sites varied in terms of their success in collecting income and benefits information, but why such variation exists is unclear.

Each enrolled participant in the CRP was also asked to complete a Program Feedback form at the point of case closure. However, given low initial response rates for the Program Feedback form, the Children's Trust Fund changed the procedures for administering this form midway through the implementation period. These changes involved providing sites with extra funds to offer incentives ($10) to program participants to complete the form at the case closure stage. Participants who agreed to complete the form were provided with a stamped, addressed envelope to mail to the evaluators, which participants could choose to mail from the CRP site or from home. Provision of feedback incentives was significantly associated with increased completion of feedback forms (51% among those who received the incentive vs. 17% among those who did not).

In the context of the CRP service intervention, contacts with families ranged from telephone and written contacts to more service intensive contacts such as visits to the family's home and family team meetings (see Table 3). Overall, telephone and home contacts were quite prevalent; over 80% of CRP participants were visited in their homes at least once, and nearly 90% were contacted at least once by telephone. Written contacts occurred with 39% of families enrolled in CRP; and approximately the same proportion of participants met with CRP staff at the program site (14%) and at other community locations (15%). Only 3% (N=12) participants were involved in a family team meeting during the final report evaluation period. See tables 3 and 4 for information on type and number of contacts and family success in CRP.

Table 3 Percent of enrolled participants with each type of contact (for those with completed contact forms, N=433)

Type	Number	%
Telephone	384	88.7%
Family home	363	82.9%
Program office	62	14.3%
Other community location	66	15.2%
Written communication	169	39.0%
Family team meeting	12	2.8%

As shown in Table 4, visits to the families' homes also occurred relatively frequently, with an average of three home contacts overall. There was considerable variation in the number of visits to family homes by site, ranging from an average of about 2 visits per family to almost 14 visits per family. With the exception of telephone contacts (mean = 4), all other forms of contact were relatively infrequent. There was also significant variation in the number of telephone contacts by site, ranging from 0 to an average of 20 telephone contacts per family.

Table 4 Mean number of contacts by type (for those with completed contact forms, N=433)

Type	Mean	Standard Deviation	Range
Telephone	4.3	5.3	0-51
Family home	3.0	4.2	0-43
Program office	.4	1.5	0-15
Other community location	.31	1.1	0-12
Written communication	.6	1.1	0-13
Family team meeting	.04	.3	0-3

As noted above, 73% of CRP participants completed an Income and Benefits Inventory during their service period. Table 5 provides the prevalence of benefit receipt for a range of benefits, most of which are income-tested. Within this subset of participants, approximately 64% reported currently receiving FoodShare (the Supplemental Nutrition Assistance Program (SNAP; formerly called Food Stamps), nearly 82% reported having some form of health insurance (Medicaid, Badger Care, Badger Care Plus, or some other form of insurance), close to 40% reported receipt of Women, Infant, and Children's (WIC) Program benefits, and a similar percentage report receiving some form of child support payments or alimony (37%). One quarter of participants reported that they receive disability benefits for someone in their family, and 30% had received the Earned Income Tax Credit (EITC). Relatively few participants reported receipt of unemployment insurance benefits (8%), housing assistance (15%), child care subsidies (13%), and Temporary Assistance for Needy Families (TANF, or "Wisconsin-Works/W-2"; 7%).

Table 5 Income and benefits receipt at enrollment (for participants with completed income and benefits inventories; N=317)

Income Source	%
Temporary Assistance to Needy Families/Wisconsin Works	6.8%
FoodShare/FoodStamps/Supplemental Nutrition Assistance Program	63.8%
Medicaid/Badgercare/Badgercare Plus or other insurance	81.8%
Medicaid Mileage Reimbursement	10.0%
Child support/alimony	37.0%
Child care subsidies	13.1%
Disability benefits	25.5%
Housing assistance	15.2%
Women, Infants, and Children	40.8%
Earned Income Tax Credit	29.4%
Unemployment benefits	8.3%
Social security benefits	4.5%
Worker's compensation	0%
Foster care/adoption assistance	1.9%
Financial support from ex-partner	4.5%
Homestead tax credit	10.9%
Utility assistance	32.0%
Crisis assistance	9.9%
Other	7.1%

A smaller subgroup (N=144, 33% of enrolled participants) answered information on questions pertaining to their monthly income amounts, and amount needed to "get by" each month. The average monthly income reported by this subgroup was $1,134 (range $0 - $5,000), while the reported needed income averaged $1,500 (range $300 - $8,500). These findings suggest that participants had income levels that may meet eligibility criteria for a range of public benefits, but also that monthly incomes were, on average, $369 short of being adequate to meet monthly expenses.

Service Goals and Progress

Table 6 presents the service goals that were identified by CRP participants in collaboration with CRP workers. Approximately 40% of participants had at least one service goal related to parenting needs or needs related to the home environment (e.g., safety, cleanliness). Nearly half of participants identified a need related to their economic situation. Another 44% identified service needs related to their personal well-being (e.g., mental health treatment, substance abuse treatment, domestic violence victimization, family planning, educational needs); 15% identified service goals related to their children's health or behavioral needs; and approximately 18% had service goals related to other types of service needs.

Table 6 Service goals (N=435)

Service Goal	**%**
Parenting and home environment	39.8%
Income and benefits-related	48.3%
Child health/behavior	15.2%
Parental well-being	44.1%
Other resource needs	17.7%

Table 7 repeats this distribution of service goals, and compares it to the distribution of referral reasons designated by CPS staff. As shown, parenting concerns were the predominant referral reasons, but only 40% of these CRP participants ultimately identified parenting concerns (in collaboration with CRP workers) as a service need. Conversely, only one-quarter of CRP participants were referred for income-related reasons, whereas almost 50% ultimately had service goals related to such needs. The percentages of participants who were referred for child-related service needs or needs related to parental well-being are smaller than the percentages of participants with service goals related to these concerns. These discrepancies potentially reflect inaccurate assessments by CPS workers (e.g., given the likelihood of missing information or lack of direct contact with participants at the maltreatment report stage), but a likelier explanation is that the collaborative goal-setting process between CRP worker and participant gives rise to a different set of service priorities than the CPS process of identifying risks and safety concerns. For this reason, the original maltreatment report details should not be used to guide the goal setting process—families should feel free to articulate their needs and prioritize them as they see fit.

Table 7 Service goals and related referral reasons (N=435)

Service Goal	% with goal	% with referral reason
Parenting and home environment	39.8%	74.9%
Income and benefits-related	48.3%	27.6%
Child health/behavior	15.2%	9.7%
Parental well-being	44.1%	35.6%
Other resource needs	17.7%	29.7%

CRP participants often identified more than one service goal, and with input from CRP workers, prioritized these service goals according to their urgency or imminence. Table 8 shows that less than 8% of participants had service goals involving "urgent" needs, but over one-third of participants had at least one service goal involving "great" need. Another 38% of participants had one or more service goals involving moderate needs, and 20% identified service needs that were characterized as "minimal."

Table 8 Service goals level of need (N=435)

Level of Need	%
Minimal	20.2%
Moderate	38.1%
Great	34.1%
Urgent	7.6%

In terms of service goal progress and attainment, over half of participants (57%) achieved at least one service goal, as assessed by the CRP worker; 70% made significant progress toward at least one service goal. Table 9 presents the results of logistic regression analyses predicting goal progress (significant progress or attainment), and attainment. Visits to the family's home by CRP workers were associated with making goal progress (defined as significant progress or attainment; this finding is marginally statistically significant for goal attainment only). Other statistically significant predictors of goal progress included having a service goal related to parenting or the home environment, having a service goal related to an income need, and having a service goal related to parental well-being. The only statistically significant predictor of goal attainment was having a service goal related to an income need. This could reflect greater engagement with CRP services around income-related needs, but may also arise because some income-related needs are more easily addressed than other types of service needs.

Table 9. Service factors associated with goal progress and attainment (N=435)

	Significant progress toward goal attainment/ Goal attainment		Goal attainment	
	Odds ratio	(SE)	Odds ratio	(SE)
Any visits to the family's home	2.64**	(.33)	1.74^{+}	(.32)
Any visits at CRP site	1.45	(.40)	2.09^{+}	(.38)
Any family team meetings	2.67	(1.19)	2.49	(.27)
Any written contacts	.79	(.26)	.94	(.24)
Any telephone contacts (reference group)	-	-	-	-
Service goal: parenting and home environment	1.84*	(.28)	.96	(.25)
Service goal: income and benefits-related	3.11***	(.31)	2.60***	(.28)
Service goal: child health/behavior	1.89^{+}	(.38)	1.87^{+}	(.33)
Service goal: parental well-being	2.27**	(.28)	.92	(.25)
Service goal: other resource needs (reference group)	-	-	-	-
Constant	.18**	(.55)	.30	(.51)

***p<.001; **p<.01; *p<.05; $^{+}$p<.10; controls for CRP site, family referral and demographic characteristics, and prior CPS involvement not shown.

Table 9 shows that having a visit in the family's home is a predictor of making significant progress toward attaining a service goal. Table 10 explores this relationship further by examining the role of the number of visits in their home a family received and the number of months a family received these visitsf. First, however, it is important to note that 98% of all visits occurred within six months of program enrollment.

There was no significant relationship between the number of visits in the family's home and making significant progress toward goal attainment or achieving a goal. However, the length of time a family received visits in their home was associated with both variables. Having these visits for a longer period of time (within a six month time frame) was significantly associated with achieving a service goal, and marginally associated with making significant progress toward attaining a goal.

Table 10. Goal progress and attainment related to receiving CRP in the family's home

	Significant progress toward goal attainment/		Goal attainment	
	Odds ratio	(SE)	Odds ratio	(SE)
Number of visits in the family's home	.991	(1.104)	.923	(1.132))
Number of months visits were received	1.409+	(1.224)	2.077**	(1.289)

***p<.001; **p<.01; *p<.05; $^{+}$p<.10; controls for CRP site, family referral and demographic characteristics, and prior CPS involvement not shown.

Program Satisfaction

Without the benefit of a comparison group, it is difficult to gauge the impact of the CRP on participant and family well-being. However, several suggestive findings emerged from descriptive analysis of participants' assessments of family strengths measured at entry in the CRP and at exit from the CRP. Ninety-nine (23%) of the 435 enrolled participants completed the Strengths Assessment at intake and follow-up. Family strengths were measured with six items related to a participant's perception of the availability of social and instrumental support, knowledge and self-efficacy related to accessing community resources, and feeling that one's family had adequate resources. A high score on the scale indicates fewer self-assessed strengths. Between program entry and exit, the average score on the Strengths Assessment measure dropped from 12.9 to 8.7 ($p<.01$), reflecting a significant improvement in family strengths, as assessed by the primary caregiver.

Differences between those who completed the assessment at both points and those who did not were also analyzed. Service characteristics were also compared, and several significant differences were identified for the group that completed follow-up forms compared to those who did not. Those with follow-up information were more likely to have had a visit in their own home during their participation in CRP than participants without follow-up forms (97% vs. 79%), and more likely to have an income-related service goal than participants lacking a follow-up form (66% vs. 33%). Other types of service goals (e.g., related to parenting, parental well-being, child behavior or health issues) did not explain differences between those who returned follow-up forms and those who did not. It is not clear whether receiving the intervention in a family's home explains a greater tendency to engage in CRP services, or are simply just more likely the longer a family remains engaged in CRP services. Although there are almost certainly other (unmeasured) factors that are associated with returning feedback forms, the finding that participants assess family strengths more positively at program exit is suggestive of program satisfaction, if not program impact. More rigorous assessments involving comparison groups are needed, however, before conclusions about program impact can be drawn.

Questions about program satisfaction are also administered when participants exit the CRP. Participants rated the extent to which they found the program beneficial overall, whether the program helped them manage stress, whether they felt respected by staff, whether their ideas were welcomed and included, whether they made use of resources, and made positive changes in their lives as a result of program participation. On all items, the average rating was between "strongly agree" and "somewhat agree," suggesting a high degree of program satisfaction. Although a select group (N=99) completed program feedback forms, this finding provides some indication that the CRP intervention is viewed positively by program participants.

Summary of Main Findings

- Service acceptance rates varied across sites, from 28% to 83%, with an average acceptance rate of 54%.
- Referral rates from CPS to CRP were low relative to the potential pool of eligible families.

- The majority of referrals to CRPs were families screened out of CPS at the report stage, but CRP workers were less successful in engaging these families than families at different "front-end" junctures.
- Over 80% of participants received at least one visit to their home from a CRP worker, and these visits were associated with making significant progress toward one or more service goals.
- The reasons for referring families to the CRPs differed from the service needs articulated by CRP participants; CPS referrals were most commonly related to parenting needs, whereas the service needs identified by CRP participants were most often related to income needs.
- Although participant reports of public benefit receipt were relatively low at CRP intake, most participants reported income levels that are likely to meet income-tested eligibility criteria for a range of public benefits.
- The majority (70%) of participants made significant progress toward at least one service goal, and 57% achieved at least one goal, as determined by CRP workers; having an income-related service goal was highly predictive of goal attainment.
- Participants assessed their families' strengths more positively at program exit compared to program entry, and participants reported a high degree of program satisfaction at program exit.

Conclusion

The Community Response Program (CRP) Pilot Initiative funded by the Wisconsin Children's Trust Fund and implemented in eleven sites across the State showed promising results with respect to engaging and serving families previously not served by CPS systems due to insufficient levels of risk. Given findings from the extant literature suggesting that this population remains at risk of returning to CPS due to unresolved or escalating levels of risk, the CRP model helps to fill a critical gap in the child maltreatment prevention continuum of services.

The implementation evaluation offers several valuable insights about the characteristics of families served by CRPs, their service needs, and aspects of this model that are associated with positive service outcomes for families. Whereas over three-quarters of families were referred by CPS staff for parenting-related concerns, collaborative goals developed by the CRP participants and CRP workers were most likely to be associated with income-related needs. Given that participating families reported relatively low levels of monthly income, as well as low levels of monthly income relative to income needs, there may be reason to suspect that the population targeted by CRPs could benefit from services designed to address economic instability. One of the strongest predictors of service goal attainment—having an income-related service goal—further suggests that the CRP models are capable of engaging and successfully working with families around their economic needs.[17]

[17] Due to the findings that families with economic goals were more likely to attain their goals, and that many families who were potentially eligible for benefits and not receiving them, CTF piloted an economic support version of Community Response in La Crosse from May of 2010-2011. In addition, they will begin funding a randomized control experiment in Milwaukee in July of 2011 to determine the preventive role of economic supports in child maltreatment.

Several factors are essential to consider in the design and implementation of CRPs. A clear articulation of the service model, including the target population, referral criteria, outreach mechanisms and engagement strategies, service array, and the criteria for closing a case is critical. Moreover, these aspects of the service model should be continually monitored, given findings from the implementation evaluation related to changes over time in the intended target population in several sites.

The population served by the Wisconsin CRP Pilot Initiative encompasses families struggling with a range of service needs and risk factors associated with child maltreatment. The CRP model offers a strategy for systematically targeting these families for the purpose of child maltreatment prevention. As Wisconsin strives to round out its prevention service continuum, the CRP model should be considered a critical element of the service array.

Appendix A: Service Forms

INTAKE FORM

Today's date: __/__/____		***CRP intake staff initials***: _____	
Name: Primary caregiver: _____ _____ _____ (first, middle, last) ***eWISACWIS Case Head I.D.*** (if applicable/known): _____ If applicable, partner: _____ _____ _____ (first, middle, last)			
Contact information:	Address:	Phone numbers:	E-mail:
Sex: ☐ Female ☐ Male	***Family structure:*** Living with partner: ☐ Yes ☐ No ☐ Unknown Number children in home: # ☐ Unknown		***Caregiver/partner pregnant?*** ☐ Yes ☐ No ☐ Unknown
Race/ethnicity (check all that apply): ☐ American Indian or Alaskan Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ White ☐ Unknown ☐ Other (specify):		***Primary home language:*** ☐ English ☐ Spanish ☐ Hmong ☐ Unknown ☐ Other (specify):	
Caregiver Disability: ☐ Yes ☐ No ☐ Unknown		***Child Disability***: ☐ Yes ☐ No ☐ Unknown	
Source of referral to CRP: ☐ CPS ☐ Self-referral ☐ Other (specify):			☐ Check if re-referral
[If referred from CPS, check one]: ☐ Screened out/no investigation ☐ Investigated/not substantiated ☐ Investigated/substantiated ☐ Services intake report ☐ Unknown ☐ Other (specify):			
Reasons for referral to CRP (check all that apply):	☐ Insufficient income/benefits eligibility ☐ Health care access (child or caregiver) ☐ Nutrition/food/hunger concerns ☐ Utilites (e.g., gas, electric, phone) ☐ Housing/homelessness issues ☐ Unemployment/underemployment ☐ Parenting/caretaking concerns (e.g., inadequate supervision, discipline, knowledge) ☐ Problems with home environment (e,g,, unclean, unsafe) ☐ Child health/behavior concerns ☐ Concerns about unborn child/prenatal care ☐ Caregiver alcohol or drug use ☐ Mental health concerns related to caregiver(s) ☐ Domestic violence issues ☐ Access to community resources (specify): ☐ Other (specify): Additional Notes:		
Assigned to CRP staff person (name):	***Dates and outcomes of attempted contacts prior to enrollment:***		
	__/__/____ ☐ Not available ☐ Declined CRP ☐ Family accepted CRP ☐ At capacity/unable to serve at this time	__/__/____ ☐ Not available ☐ Declined CRP ☐ Family accepted CRP	__/__/____ ☐ Not available ☐ Declined CRP ☐ Family accepted CRP __/__/____ ☐ Not available ☐ Declined CRP ☐ Accepted CRP
CRP decision after family accepts CRP (check all that apply)	☐ CRP staff enroll family in program [Date of enrollment/acceptance]: __/__/____ ☐ Family referred back to CPS prior to CRP enrollment [Date]: __/__/____ ☐ Family referred elsewhere prior to CRP enrollment [Specify where]: ☐ Family deemed ineligible for further CRP intervention [Reason(s)]:		

Family has had prior involvement with CPS? ☐ Yes ☐ No ☐ Unknown	***Notes:***
Eligible for Medical Assistance case management services? ☐ Yes ☐ No ☐ Unknown	***Notes:***
Family strengths identified by referral source: ***Notes:***	
Other comments from referral source: ***Notes:***:	

Family/Household Members Who May Participate in or Benefit from CRP services

First name	***Age***	***Sex***	***Relation to PC***	***Employment***	***Education level***
Primary caregiver:		☐ Male ☐ Female		☐ Full-time ☐ Part-time ☐ Not working	☐ HS degree/GED ☐ Less than HS ☐ More than HS
Partner/spouse:		☐ Male ☐ Female		☐ Full-time ☐ Part-time ☐ Not working	☐ HS degree/GED ☐ Less than HS ☐ More than HS
Other family or household members:					
		☐ Male ☐ Female		***Notes:***	
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			
		☐ Male ☐ Female			

ENROLLMENT AND PROGRESS FORMS

Parent/Caregiver First & Last Name: _____

CRP Staff initials: _____ Parent/Caregiver signature: _____

Initial date of assessment: __/__/____

Progress key:

0=contact attempted, but not made
1=need is worse; still a need/goal
2=unchanged; still a need/goal
3=some progress; still a need/goal
4=significant progress; still a need/goal
5=resolved or attained goal

Service need (1 or more may be grouped)	**Level of need** (CRP & family determine together)	**Goal and steps/activities toward goal**				**Monthly Progress Toward Goal (use keys above)**
1.	1.minimal ☐ 2.moderate ☐ 3.great ☐ 4.urgent ☐	Goals: Activities/Steps (and by whom): Referral to: Dates:	__/__/____	__/__/____	__/__/____	Date: Progress: Date: Progress: Date: Progress: Date: Progress:
2.	1. minimal ☐ 2. moderate ☐ 3. great ☐ 4. urgent ☐	Goals: Activities/Steps (and by whom): Referral to: Dates:	__/__/____	__/__/____	__/__/____	Date: Progress: Date: Progress: Date: Progress: Date: Progress:
3.	1. minimal ☐ 2. moderate ☐ 3. great ☐ 4. urgent ☐	Goals: Activities/Steps (and by whom): Referral to: Dates:	__/__/____	__/__/____	__/__/____	Date: Progress: Date: Progress: Date: Progress: Date: Progress:

Service area key:

H=housing T=transportation U=utilities I=income & benefits ED=education/job skills E=employment HE=home environment
B=budgeting/financial planning HC=health care access CH=child health P=parenting PNC=prenatal care CC=child care N=nutrition/food
FP=family planning FV=family violence MH=mental health AODA=alcohol/drug use L=legal issue OTH=other (describe):

CONTACT LOG

Please record the number of each type of contact monthly from the point of case opening.

Type of contact key:

T = telephone	O = other community location	H = in family home
W = written communication	P = program office	F = family team meeting

Year:

Month: January	T	H	P	O	W	F
Month: February	T	H	P	O	W	F
Month: March	T	H	P	O	W	F
1ST Quarter **Total**	T	H	P	O	W	F
Month: April	T	H	P	O	W	F
Month: May	T	H	P	O	W	F
Month: June	T	H	P	O	W	F
2nd Quarter **Total**	T	H	P	O	W	F
Month: July	T	H	P	O	W	F
Month: August	T	H	P	O	W	F
Month: September	T	H	P	O	W	F
3rd Quarter **Total**	T	H	P	O	W	F
Month: October	T	H	P	O	W	F
Month: November	T	H	P	O	W	F
Month: December	T	H	P	O	W	F
4th Quarter **Total**	T	H	P	O	W	F

Year:

Month: January	T	H	P	O	W	F
Month: February	T	H	P	O	W	F
Month: March	T	H	P	O	W	F
1ST Quarter **Total**	T	H	P	O	W	F
Month: April	T	H	P	O	W	F
Month: May	T	H	P	O	W	F
Month: June	T	H	P	O	W	F
2nd Quarter **Total**	T	H	P	O	W	F
Month: July	T	H	P	O	W	F
Month: August	T	H	P	O	W	F
Month: September	T	H	P	O	W	F
3rd Quarter **Total**	T	H	P	O	W	F
Month: October	T	H	P	O	W	F
Month: November	T	H	P	O	W	F
Month: December	T	H	P	O	W	F
4th Quarter **Total**	T	H	P	O	W	F

REPORT TO CPS MADE BY CRP STAFF PERSON AFTER FAMILY ENROLLMENT IN CRP: Yes ☐ No ☐
[IF YES, DATE: __/__/____] REASON(S): _____

DATE OF CASE CLOSURE: [__/__/____]
PROVIDED FEEDBACK INCENTIVE: Yes ☐ No ☐

FLEX FUNDING PROVIDED TO FAMILY: Yes ☐ No ☐
AMOUNT: _____ **FOR:** _____ **FOLLOWED-UP:** Yes ☐ No ☐
NOTES: _____
LOCAL FUNDING PROVIDED TO FAMILY (NOT IN-KIND SERVICES): Yes ☐ No ☐
AMOUNT: _____ **FOR:** _____ **SOURCE(S):** _____

CASE CLOSE REASON(S):
☐ Service goal(s) attained
☐ Family moved out of area
☐ Family no longer engaged
☐ Service time limit reached
☐ Other: _____

PRIMARY CAREGIVER SELF-ASSESSMENT OF STRENGTHS

"What are some of the strengths or special things about your family?"

First Name: _____ Last Name: _____ Date Completed: ____/____/____

"Please read each statement below, and circle the response that indicates whether you strongly agree, somewhat agree, somewhat disagree, or strongly disagree. If you are unsure, you can say that, too."

	Strongly Agree 1	Somewhat Agree 2	Unsure 3	Somewhat Disagree 4	Strongly Disagree 5
I have relationships with people who provide me with support when I need it.	☐	☐	☐	☐	☐
I know who to call and where to go in the community when I need help	☐	☐	☐	☐	☐
I feel good about my ability to parent and take care of my children.	☐	☐	☐	☐	☐
I have people to talk to when I am worried about my children or my parenting	☐	☐	☐	☐	☐
I am able to meet family's needs with the money and resources I currently have	☐	☐	☐	☐	☐
I know how to seek help from the agencies in my community to get things that my family needs.	☐	☐	☐	☐	☐

First Name: _____ Last Name: _____ Today's Date: __/__/____ Date Completed: __/__/____

INCOME AND BENEFITS INVENTORY

"These questions ask about your family's current sources of income and various benefits you may receive or be interested in receiving. Knowing this information will help us assess whether your family has all of the benefits that you may be eligible to receive. Would you be willing to complete this assessment?" ☐ Yes ☐ No	Currently receiving?	**[If not currently receiving, record notes on potential eligibility]:**
TANF or W-2 grant? (cash grant only)	☐ Y ☐ N	
Food stamps?	☐ Y ☐ N	
Badger Care, Medical Assistance (MA), or other health insurance? Record type:	☐ Y ☐ N	
MA Mileage Reimbursement?	☐ Y ☐ N	
Child support or alimony?	☐ Y ☐ N	
Child care subsidies or help from the county or city with child care payments?	☐ Y ☐ N	
Disability benefits (such as Supplemental Security Income or SSI, or OAS-DI)?	☐ Y ☐ N	
Public housing subsidy or other form of housing assistance?	☐ Y ☐ N	
WIC (Women, Infants, and Children's assistance)?	☐ Y ☐ N	
Earned Income Tax Credit (EITC) or state earned income credit?	☐ Y ☐ N	
Unemployment Insurance?	☐ Y ☐ N	
Social security benefits (SSA) or any other private or government retirement pension?	☐ Y ☐ N	
Worker's Compensation as a result of a job-related injury?	☐ Y ☐ N	
Foster child payments or adoption subsidies?	☐ Y ☐ N	
Kinship Care payments?	☐ Y ☐ N	
Utility assistance (e.g., Energy Services)?	☐ Y ☐ N	
Homestead Tax Credit?	☐ Y ☐ N	
Crisis assistance or emergency assistance?	☐ Y ☐ N	
Any other sources of income? (Specify):	☐ Y ☐ N	

"Think of all of the things your family spends money on, including food, rent, car payments, and other bills—how much money do you think you need <u>each week</u> or <u>each month</u> to be able to get by?"

$ _____/week OR $ _____/month

"Thinking of all your sources of income, including any money from work that you do, from family or friends, or from any of the sources in the above table—how much money does your family currently have <u>each week</u> or <u>each month</u> to pay for your expenses?"

$ _____/week OR $ _____/month

COMMUNITY RESPONSE PROGRAM FEEDBACK FORM

Please clearly print your first and last name and place this form in the stamped, addressed envelope provided to you by program staff. These program staff will NOT receive or see the responses you gave. This information will be used by researchers who are trying to understand the effectiveness of the program.

First name: _____ Last name: _____

Provide your address only if this feedback form was mailed to you by your worker, or if you took the feedback form home with you to mail in yourself. The University evaluators will send your gift certificate when they receive your completed form. You do not need to provide your address if you are completing the form at the Community Response Program Office, and leaving it with your worker in a sealed envelope

Street address: _____
City, state, zip: _____

Please respond to the following items on a scale of 1 to 5, with 1 being "strongly agree" and 5 being "strongly disagree."	***Strongly Agree 1***	***Somewhat Agree 2***	**Unsure 3**	***Somewhat Disagree 4***	***Strongly Disagree 5***
This program was helpful to me.	☐	☐	☐	☐	☐
I feel good about my ability to take care of my children	☐	☐	☐	☐	☐
This program helped me manage stress in my life.	☐	☐	☐	☐	☐
My ideas were welcomed and included in the program.	☐	☐	☐	☐	☐
I am able to meet my family's needs with the money and resources I currently have.	☐	☐	☐	☐	☐
Program staff at the community response program treated me with respect.	☐	☐	☐	☐	☐
I have relationships with people who provide me with support when I need it.	☐	☐	☐	☐	☐
The program helped me and my family reach our goals.	☐	☐	☐	☐	☐
The program helped improve my family relationships.	☐	☐	☐	☐	☐
I know who to call and where to go in the community when I need help	☐	☐	☐	☐	☐
I was able to use the information and contacts my support worker gave me.	☐	☐	☐	☐	☐
I have people to talk to when I have worries about my children or my parenting.	☐	☐	☐	☐	☐
I know how to seek help from the agencies in my community to get things that my family needs	☐	☐	☐	☐	☐
I made positive changes in my life because of this program.	☐	☐	☐	☐	☐
Are there things that should be changed in the program to make it better and more helpful in the future?	If yes, please describe (use other side of page if needed):				

THANK YOU FOR TAKING THE TIME TO HELP US IMPROVE OUR SERVICES!

Appendix B: Implementation Questionnaire

Community Response Program (CRP) Initiative
Implementation Questionnaire for CRP Program Staff
March 15, 2007

We are working on the implementation evaluation component of the Community Response Program (CRP) initiative supported by the Children's Trust Fund. In order to gauge progress and understand barriers that arise in the delivery of these models, we are asking a series of questions. We are requesting that the person from your site who is most knowledgeable about the daily operations of the CRP program answer these questions as accurately as possible.

We recognize that some of this information may have been included in your original proposals; however, we also recognize that many sites have made changes to their protocols since their original proposal. Answering these questions at the present time will help us get a better sense of how the CRP models are working in practice.

Please be as specific as possible and feel free to include additional information that you feel would be helpful to understanding the CRP service delivery at your organization. You can include your answers within this document and either email responses back to us (Kristi and/or Lonnie), or fax your responses to the attention of Kristi Slack or Lonnie Berger at the School of Social Work (fax: 608-263-3836).

County/Site:_____

Your name (for follow-up, if clarifications are needed):_____

1. Where are your CRP program staff housed?

2. Please list all community agency partners in the program:

3. Besides child protective services (CPS), are there any other sources of direct referrals to your CRP? If so, please list them:

4. a. In addition to your CRP partners, what service providers are aware of the CRP in your community?

   b. How were these service providers informed about the CRP? (E.g., letter, email, meeting, other?) Please explain.

5. What criteria are used to determine referrals to your CRP?
   a. Given your understanding of your site's CRP model, who <u>should</u> be referred to CRP?

   b. Who should NOT be referred to CRP?

   c. Is CPS referring families to your program who you feel should not be referred? Please describe these families.

   d. To the best of your knowledge, is CPS referring ALL families to you who meet your program's referral criteria? If not, please explain why this may be occurring and which families may not be being referred.

e. In what capacity were CRP-referred families involved with CPS prior to their referral to the CRP? Please check all that apply. If it is possible to approximate the percentages in each relevant category, please do so.

- □ Investigated, substantiated, and CPS case was opened _____%
- □ Investigated, substantiated, but no CPS case was opened _____%
- □ Investigated, unsubstantiated _____%
- □ Referral to CPS, but not investigated _____%
- □ Not referred from CPS _____%

f. Does your CRP site accept <u>all families</u> that are referred, or do the CRP staff themselves screen out some families? If applicable, please describe any criteria used to screen out families referred to CRP.

g. In order to best understand the referral process, we would like to contact someone from your local CPS agency who is responsible for making referrals to your CRP to gain a better understanding of the criteria they are using to make referrals. If more than one person, we would like to contact someone who has made most of the referrals so far. Please provide the name, email and/or phone number of the appropriate CPS staff person:

6. If a family has met criteria for the CRP, how do CRP staff make the initial contact with the family? Please check all that apply.
   - □ Phone call
   - □ Letter
   - □ Visit to home
   - □ Other, please specify: _____

   a. Prior to CRP staff's involvement, does the CPS worker inform the family that they are being referred to CRP?

   b. What is the role or title of the CPS worker, CRP staff person, or other service provider who initially informs the family of their referral to CRP?

7. From the point of CRP's acceptance of a referral, what is the typical time frame in which a family is contacted for CRP intake?

    a. Where does the CRP intake typically occur?

    b. What is the role and title of the CRP staff person who completes the CRP intake?

    c. Have any sections or questions on the intake form been difficult for the staff to ask or for clients to answer? Please explain.

8. Once connected to CRP, what are possible services options?

    a. What has been or what are you expecting to be the most common service offered?

    b. Have any sections or questions on the enrollment and/or progress form been difficult for the staff to ask or for clients to answer? Please explain.

9. What services could a client expect to receive within:
    a. 1 week of CRP intake?

    b. 2 weeks of CRP intake?

    c. 1 month of CRP intake?

    d. 6 months of CRP intake?

10. How is it determined when a CRP case should be closed?

    a. Who typically makes this decision?

    b. Are services time-limited?

    c. How is case closing communicated with the client?

    d. Is there further communication with the client after case closing?

11. What is/are your CRP site's measure(s) of success? Please also comment on whether and how you determine if family functioning improved.

12. In addition to the program feedback form that has been adopted, how does your CRP gain feedback from:
    a. Clients?

    b. Service providers?

    c. Community stakeholders?

13. Any additional information or comments: